St John of God Hauora Trust

Young Parents' Development Referral

Waipuna Young Parents Service and Pacific Young Parents Service

Young parents have many hopes and goals for their families. We are a service that supports young parents in the process of achieving these. Some goals that have been identified as important by young parents are: a warm safe home and enough money to live on; to feel good about themselves and to make good choices; access to further education and employment opportunities; how to provide gentle guidance and clear boundaries to their children; to have fun and enjoy life.

This can be through parenting, self development, social and activity-based groups, and in some cases may include home-based support.

To make a referral to the Young Parents' Support Team, please fill in this referral form and email, fax or mail it to:

Fax	03 386 2158
Mail	St John of God Waipuna, P O Box 24127, Eastgate, Christchurch
Email:	referralswaipuna@sjog.org.nz
Online:	www.sjog.org.nz and look under 'other services'

Please note that it is necessary for the young person to be aware of the referral.

Client Criteria:

Parents to be *23 years and under*:
YP2B (Young Parents 2Be Pregnancy & Parenting Education)
Please visit www.sjog.org.nz for our latest timetable.

Parents *19 years and under*:
We offer intensive one on one social work support or the opportunity to attend a range of education and support programmes.
Please visit www.sjog.org.nz for current courses.

Parents *19-25 years*:
We offer a range of group education and support programmes.
Please visit www.sjog.org.nz for current courses.

Parents *25 years and under*:
We offer "Watch Wait and Wonder" intervention for relationship, attachment and/or behavioral issues.

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Young Parents' Development Service Referral Form

Referral date: _____/_____/_____

Type of referral:

SELF REFERRAL ☐

AGENCY REFERRAL ☐ → **Is the young person referred aware of referral? Yes / No**

Client Information:

Name:		**Gender**: ☐ Female ☐ Male
Address:		
Telephone:		
Email Address:		
NHI:		
Date of Birth	/ /	
School		

Ethnicity: ☐ Maori → Please indicate iwi/tribal affiliation: _____

☐ Samoan ☐ Tongan ☐ Fijian ☐ Niuean ☐ Cook Island

☐ NZ European ☐ Other (Please indicate)

Children or Estimated Date of Delivery:

Name	**Gender**	**DOB**	**Ethnicity (if applicable provide iwi)**
	M / F		
	M / F		
	M / F		
EDD (Estimated Delivery Date)			

Reasons for Referral:

Have these been discussed with the client? Yes / No

Tick all that apply.

- ☐ Alcohol/Drug Dependence or Abuse
- ☐ Behavioural Issues
- ☐ Custody/Access/Paternity Issues
- ☐ Family Conflict
- ☐ Financial/Budgeting/Resource Issues
- ☐ Grief/Loss Issues
- ☐ Isolation
- ☐ Learning Difficulties/Literacy
- ☐ Mental Health Issues
- ☐ Physical/Psychological Abuse or Neglect
- ☐ Sexual Abuse
- ☐ Social Skills/Peer Problems
- ☐ Truancy Issues
- ☐ Youth Offending
- ☐ YP2B Pregnancy & Parenting Education
- ☐ Anger Management Issues
- ☐ Attachment
- ☐ Bullying
- ☐ Currently Pregnant
- ☐ Family Violence
- ☐ Gambling
- ☐ Housing/Accommodation Issues
- ☐ Lack of Support
- ☐ Legal/Court Issues
- ☐ Parenting Support/Issues
- ☐ Relationship Issues
- ☐ Self Harm
- ☐ Suicidal Behaviour
- ☐ Self-Esteem Issues
- ☐ Young Parent 14 – 19 yrs

Referring Agency:

Agency's Name:	
Referrer's Name:	
Role:	
Telephone:	
Email:	
Address:	

Will you be having ongoing contact with the person being referred after this referral? Yes / No
If yes, what do you see your role as being and what areas will you be assisting with?

Children or estimated Date of Delivery:

Name	DOB	Gender	Ethnicity (if applicable iwi)
		M/F	
		M/F	
		M/F	

Current Living Circumstances

Are you currently living with:

☐ Partner ☐ Family ☐ Renting/Boarding ☐ Alone

Other: _____

Do you need help/assistance with accommodation?	**Yes**	**No**
	☐	☐

Medical Information

	Yes	**No**
Do you have a midwife?	☐	☐

If so who?
(If not we can help you find one) _____

Do you have a GP	☐	☐

If so who? _____

Have you been/are you involved with mental health services?	☐	☐

Please state any services you are currently involved with _____

Do you have a mental health Services?	☐	☐

How often do you use:	**Do not use**	**Use once a Week**	**Use Several Times a week**
Alcohol	☐	☐	☐
Cannabis	☐	☐	☐

Other substances (Please identify) _____

	Yes	**No**
Do you smoke?	☐	☐
Would you like support to create a Smoke free environment for your baby?	☐	☐

Family Safety and Support

	Yes	No
I am no longer with the mother/father Of my child and am having difficulties With contact?	☐	☐
I want assistance with an access plan	☐	☐
I am currently going through mediation	☐	☐
I have care and safety concerns when my Child is spending time with her/his Mother or father?	☐	☐
Have you experienced family violence?	☐	☐
Have you been affected by violence in the past?	☐	☐
Do you have a Protection Order?	☐	☐
Have you completed an anger management course?	☐	☐
Past: Did you grow up in Child Youth and Family Services (CYFS) Care?	☐	☐
Current: Are they investigating any Concerns?	☐	☐
Current: my child is in CYF Custody?	☐	☐
Current workers details?	☐	☐
Are you seeing other professional Support in the community?	☐	☐

Past Support? (Please list) _____

Who do you identify as you main Support people? (Please list)

_____

_____